F. Direct and indirect effects on public: NONE

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D. The proposed amendments to this chapter will have a minimal impact on regulated industries because private review agents will be required to provide and use the amended Uniform Treatment Plan form for utilization review of services for the treatment of mental illness, emotional disorder, or a substance abuse disorder. If the private review agent has a supply of the prior Uniform Treatment Plan forms, these will no longer be acceptable. The cost to produce new forms would be a minimal amount.

E. Health care providers that are seeking approval for treatment plans involving mental illness, emotional disorder or a substance abuse disorder will also be required to use the amended Uniform Treatment Plan form. If the health care provider has a supply of the prior Uniform Treatment Plan forms, these will no longer be acceptable. The cost to produce new forms would be a minimal amount.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Nancy Egan, Director of Government Relations, Maryland Insurance Administration, 200 St. Paul Place, Suite 2700, Baltimore, MD 21202, or call 410-468-2488, or email to nancy.egan@maryland.gov, or fax to 410-468-2020. Comments will be accepted through February 23, 2015. A public hearing has not been scheduled.

.02-1 Uniform Treatment Plan.

A. — G. (text unchanged)

H. The uniform treatment plan form required by this regulation shall read as follows:

Note: The revised form appears at the end of the Proposed Action on Regulations section of this issue of the Maryland Register.

I. (text unchanged)

THERESE M. GOLDSMITH
Insurance Commissioner

Subtitle 12 HEALTH MAINTENANCE ORGANIZATIONS; ENTITIES THAT ACT AS HEALTH INSURERS

Notice of Proposed Action

[15-047-P]

The Insurance Commissioner proposes to amend:

(1) The **Authority Line** under **COMAR 31.12.01 Health Maintenance Organizations — Certificate of Authority and Fiscal Requirements**;

(2) Regulation **.02** under **COMAR 31.12.03 Health Maintenance Organizations — Mandatory Point-of-Service Option**;

(3) Regulations **.02** and **.04** under **COMAR 31.12.04 Dental Plans — General Provisions**;

(4) Regulation **.02** under **COMAR 31.12.05 Dental Benefit Plan Coverage — Mandatory Point-of-Service Option**;

(5) The **Authority Line** under **COMAR 31.12.06 Managed Care Organizations — Financial Compliance Requirements**; and

(6) Regulations **.04** and **.05** under **COMAR 31.12.07 Required Standard Provisions.**

Statement of Purpose

The purpose of this action is to make changes to COMAR 31.12 consistent with the MIA's review of this subtitle under the Regulatory Review and Evaluation Act.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Catherine Grason, Director of Regulatory Affairs, Maryland Insurance Administration, 200 Saint Paul Place, Ste. 2700, Baltimore, Maryland 21202, or call 410-468-2201, or email to catherine.grason@maryland.gov, or fax to 410-468-2020. Comments will be accepted through February 23, 2015. A public hearing has not been scheduled.

31.12.01 Health Maintenance Organizations — Certificate of Authority and Fiscal Requirements

Authority: Health-General Article, §§[19-701(e),] 19-705(a), *19-707,* 19-708[(b)(10)], 19-710[(d) and (h)], and 19-728, Annotated Code of Maryland

31.12.03 Health Maintenance Organizations — Mandatory Point-of-Service Option

Authority: Health-General Article, §§19-705(a)(2) and 19-710.2, Annotated Code of Maryland

.02 Required Notice.

When a health maintenance organization is the sole carrier offered to group members by a group policyholder, the health maintenance organization:

A.—B. (text unchanged)

C. As part of the application, shall provide to each group policyholder the following disclosure statement, for each point-of-service option offered:

"Under Maryland law, *if you choose a point-of-service option for your group members,* your group member may [purchase] *select* a point-of-service option as an additional benefit. A point-of-service option allows your group members to obtain health care services from physicians and other providers outside the HMO network under certain circumstances that are described in attachment A. You have the choice to either pay for this point-of-service option, pay a percentage of the cost of this option, or require your group members to pay for the entire cost of this option. The cost of the point-of-service option described in attachment A is identified in your proposal. [Please indicate below the group members who have chosen this point-of-service option.]

I have read and understand this disclosure statement and the attachments and [have provided], *if I have chosen the point-of-service option, I will provide* notice of the availability of this additional benefit to my eligible group members. Group Policyholder Signature"

31.12.04 Dental Plans — General Provisions

Authority: Insurance Article, §§2-109, 14-124(b), [14-401, 14-403, 14-405,] 14-410, 14-412, [15-112(b)(2)(ii)] *15-112(b)(1)(i)*, 15-122(b), 15-833(j), and Title 15, Subtitles 10A and 10D, Annotated Code of Maryland

.02 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) "Closed panel dental benefit contract" means a dental benefit contract that does not provide benefits for services provided by a dentist who is not a plan dentist, with the exception of:

(a) Emergency services; and

(b) Out-of-network services required by Insurance Article, §15-830, Annotated Code of Maryland.

[(1)] *(2)*—[(2)] *(3)* (text unchanged)

[(3)] *(4)* "Dental benefit contract" means a contract which provides benefits for dental services entered into between the dental plan organization and:

(a) An individual contract holder covering the:

(i) Subscriber;

(ii) Subscriber and the subscriber's dependents;

(iii) Subscriber and the subscriber's family members; [or]

(iv) Subscriber's dependent or dependents; or

[(iv)] *(v)* Subscriber and the subscriber's dependents and family members; or

(b) (text unchanged)

[(4)] *(5)*—[(12)] *(13)* (text unchanged)

[(13)] *(14)* "Subscriber" means, for:

(a) Group dental benefit contracts, the person who is eligible to be covered under the contract, other than as a dependent, by reason of satisfying the eligibility requirements of the group;

(b) Individual dental benefit contracts, the individual who applies to the dental plan organization for coverage for:

(i) [that] *That* individual only [or];

(ii) [for the] *The* individual and the individual's dependents; *or*

(iii) The individual's dependent or dependents.

.04 Dental Benefit Contract.

Each dental benefit contract shall contain the following provisions:

A.—H. (text unchanged)

I. *For closed panel dental benefit contracts:*

(1) A provision indicating that if a plan dentist refers the enrollee to a specialist who is not a plan dentist for dental services which are covered under the dental benefit contract, the dental plan organization shall be responsible for payment of the specialist's charges to the extent the charges exceed the copayment specified in the dental benefit contract; *and*

[J.] *(2)* A provision which reads substantially as follows: "If during the term of this contract none of the plan dentists can render necessary care and treatment to the enrollee due to circumstances not reasonably within the control of the dental plan organization, such as complete or partial destruction of facilities, war, riot, civil insurrection, labor disputes, or the disability of a significant number of the plan dentists, then the enrollee may seek treatment from an independent licensed dentist of the enrollee's own choosing. The dental plan organization will pay the enrollee for the expenses incurred for the dental services with the following limitations: The dental plan organization will pay the enrollee for services which are listed in the patient charge schedule as No Charge, to the extent that such fees are reasonable and customary for dentists in the same geographic area; the dental plan organization will also pay the enrollee for those services listed in the contract for which there is a copayment, to the extent that the reasonable and customary fees for such services exceed the copayment for such services as set forth in the contract. The enrollee may be required to give written proof of loss. The dental plan organization agrees to be subject to the jurisdiction of the Maryland Insurance Commissioner in any determination of the impossibility of providing services by plan dentists.";

[K.] *J.*—[M.] *L.* (text unchanged)

31.12.05 Dental Benefit Plan Coverage — Mandatory Point-of-Service Option

Authority: Insurance Article, §§2-109 and 15-114, Annotated Code of Maryland

.02 Required Notice.

A. (text unchanged)

B. The notice shall read as follows:

Under Maryland law, *if you choose a point-of-service option for your group members,* your group member may [purchase] *select* a dental point-of-service option as an additional benefit. A dental point-of-service option allows your group members to obtain dental care services from dentists and other providers outside the dental provider panel under certain circumstances that are described in Attachment A.

You have the choice to either pay for this point-of-service option, pay a percentage of the cost of this option, or require your group members to pay for the entire cost of this option. The cost of the dental point-of-service option described in Attachment A is identified in your proposal. [Please indicate below the group members who have chosen this point-of-service option.]

I HAVE READ AND UNDERSTAND THIS DISCLOSURE STATEMENT AND [HAVE PROVIDED], *IF I HAVE CHOSEN THE POINT-OF-SERVICE OPTION, I WILL PROVIDE* NOTICE OF THE AVAILABILITY OF THIS ADDITIONAL BENEFIT TO MY ELIGIBLE GROUP MEMBERS.

_____ _____

Date Group Policyholder

31.12.06 Managed Care Organizations — Financial Compliance Requirements

Authority: Health-General Article, §§[15-102,] *15-102.3*, 15-102.4(d), and 15-102.6; Insurance Article, §§2-109 and 4-311(b)(2); Annotated Code of Maryland
Ch. 331, §3, Acts of 2000

31.12.07 Required Standard Provisions

Authority: Health-General Article, §19-713(f); Insurance Article, §12-203(g); Annotated Code of Maryland

.04 Group Contract Standard Provisions.

A.—K. (text unchanged)

L. Misstatement of Age. If the premiums *or benefits* vary by age, each group contract shall contain a provision specifying an equitable adjustment of premiums *or benefits* to be made in the event the age of a member has been misstated.

[M.] (proposed for repeal)

[N.] *M.* (text unchanged)

.05 Individual Contract Standard Provisions.

A.—D. (text unchanged)

E. Reinstatement. Each individual contract shall contain in substance the following provision: "Reinstatement: If any renewal premium is not paid in full within the time granted the subscriber for payment, a later acceptance of premium in full by the HMO or by any agent authorized by the HMO to accept the premium, without requiring a reinstatement application in connection with the acceptance of the premium in full, shall reinstate the contract. However, if the HMO or the agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the contract will be reinstated upon approval of the application by the HMO or, lacking approval, upon the forty-fifth day following the date of the conditional receipt unless the HMO has previously notified the subscriber in writing of its disapproval of the reinstatement application. [The reinstated contract shall cover only loss resulting from accidental injury as may be sustained after the date of reinstatement and loss due to sickness as may begin more than ten days after the date of reinstatement. In all other respects the] *The* subscriber and HMO shall have the same rights under the reinstated contract as they had under the contract immediately before the due date of the defaulted premium, subject to any provisions endorsed on the contract or attached to the contract in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty days prior to the date of reinstatement."

F.—H. (text unchanged)

THERESE M. GOLDSMITH
Insurance Commissioner

Subtitle 13 CREDIT LIFE AND CREDIT HEALTH INSURANCE

Notice of Proposed Action

[15-048-P]

The Insurance Commissioner proposes to amend:

(1) Regulations **.04**, **.09**, **.13**, **.17**, and **.24** under **COMAR 31.13.01 Standards for Credit Life and Credit Health Insurance**; and

(2) Regulation **.19** under **COMAR 31.13.03 Standards for Credit Involuntary Unemployment Benefit Insurance.**

Statement of Purpose

The purpose of this action is to make changes to COMAR 31.13.01 and 31.13.03 consistent with the MIA's review of COMAR 31.13 under the Regulatory Review and Evaluation Act.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Catherine Grason, Director of Regulatory Affairs, Maryland Insurance Administration, 200 Saint Paul Place, Ste. 2700, Baltimore, Maryland 21202, or call 410-468-2201, or email to insuranceregreview.mia@maryland.gov, or fax to 410-468-2020. Comments will be accepted through February 23, 2015. A public hearing has not been scheduled.

31.13.01 Standards for Credit Life and Credit Health Insurance

Authority: Commercial Law Article, Title 12, Subtitle 3; Insurance Article, §§2-109, 13-110, 13-111, and 13-112; Annotated Code of Maryland

.04 Definitions.

A. (text unchanged)

B. Terms Defined.

(1) — (12-1) (text unchanged)

(13) "Joint life insurance" means insurance issued to [a debtor and spouse] *two co-debtors with an insurable interest, as defined in Insurance Article, §12-201(b), Annotated Code of Maryland,* when both are jointly and severally liable for the debt.

(14) — (20) (text unchanged)

.09 General Premium Rate Standards and Increased Rates.

A. With respect to all premium rates not eligible for filing in accordance with the case method, the Commissioner will accept as meeting the standards of Insurance Article, §13-110(b)(1) and (2), Annotated Code of Maryland, those premium rate filings which do not exceed prima facie premium rates stated in Regulations .10 — [.12] *.11* and .14 — [.16] *.15* of this chapter for the several categories of insurance described in those regulations. The prima facie premium rates in those regulations are based on the assumption that a policy fee, policy issue fee, certificate fee, or other additional charge will not be made.

B.—E. (text unchanged)

.13 Underwriting Requirements for Credit Life Prima Facie Premium Rates.

A. The prima facie premium rates used in Regulations 10 — [.12] *.11* of this chapter assume that contracts providing credit life insurance do not require evidence of individual insurability from any eligible debtor electing to purchase coverage within 30 days of the date the debtor becomes eligible.

B. If an insurer requires evidence of insurability from debtors electing to purchase coverage within 30 days of the date they become eligible and the initial amount of credit life insurance or the insurable maximum revolving credit account limit of an insured debtor does not exceed $15,000, the insurer shall reduce the premium rates stated in Regulations .10 — [.12] *.11* of this chapter by 10 percent on all:

(1) — (2) (text unchanged)

C. Subject to the conditions and requirements of Regulations .08, .09, and .18 of this chapter, the maximum premium rates shall be the rates stated in Regulations .10 — [.12] *.11* of this chapter if the:

(1) — (2) (text unchanged)

D. (text unchanged)

E. Underwriting Limitations.

(1) (text unchanged)

(2) The policy contains no provision which excludes or restricts liability for death caused in a certain specific manner or occurring while the insured has a specified status, *except that the policy may exclude death resulting from suicide within 6 months after the effective date of coverage.*

(3) — (6) (text unchanged)

.17 Underwriting Requirements for Credit Health Prima Facie Premium Rates.

A. The prima facie premium rates in [Regulations] *Regulation* .15 [and .16] of this chapter assume that contracts providing credit health insurance do not require evidence of individual insurability from any